



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TEXAS ORTHOPEDICS
MICHAEL D LOEB MD
4700 SETON CENTER PARKWAY SUITE 200
AUSTIN TX 78759

Respondent Name

TEXAS DEPARTMENT OF TRANSPORTATION

Carrier's Austin Representative Box

Box Number 32

MFDR Tracking Number

M4-12-3003-01

MFDR Date Received

MAY 29, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have been in compliance with rule §133.501 Electronic Medical Bill Processing since the effective date of January 1, 2008. We are contracted with Stone River P2P as our clearinghouse for workers' compensation claims. We are aware that not all carriers have been in compliance to receive medical bills electronically from health care providers therefore P2P must print and mail these claims. Please see attached documentation from P2P as proof of timely filing on the above referenced claim and reprocess for prompt payment per rule §133.20(b) A health care provider shall not submit a medical bill later than the 95th day after the date the services are provided."

Amount in Dispute: \$509.13

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider's billing company exceeded the 95 day limit for timely submission to the carrier for both dates of service in dispute and the request for reimbursement should be denied."

Response Submitted by: Texas Department of Transportation

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 23, 2011	Office Visit - CPT Code 99213-25	\$109.91	\$109.91
September 23, 2011	Application of Splint - CPT Code 29125	\$105.20	\$105.20
September 23, 2011	Cast Supplies - HCPCS Code Q4022	\$42.00	\$0.00
September 23, 2011	X-ray- CPT Code 73110-WP-RT	\$58.51	\$58.51
September 23, 2011	Work Status Report - CPT Code 99080-73	\$15.00	\$0.00
September 23, 2011	Wrist-hand Orthotic - HCPCS Code L3908-RT	\$55.00	\$55.00

September 23, 2011	Positioning Cushion - HCPCS Code E0190-NU	\$50.00	\$0.00
October 6, 2011	X-ray - CPT Code 73110-WP-RT	\$58.51	\$58.51
October 6, 2011	Work Status Report - CPT Code 99080-73	\$15.00	\$15.00
TOTAL		\$509.13	\$402.13

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
2. 28 Texas Administrative Code §102.4(h) effective May 1, 2005, sets out rules to determine when written documentation was sent.
3. 28 Texas Administrative Code §133.307, effective May 25, 2008, 33 *Texas Register* 3954, sets out the procedures for resolving a medical fee dispute.
4. 28 Texas Administrative Code §134.203 set out the fee guideline for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
5. 28 Texas Administrative Code §134.1, effective March 1, 2008, requires that in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be fair and reasonable.
6. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable
7. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets out medical fee guidelines for workers' compensation specific services.
8. 28 Texas Administrative Code §129.5, effective July 16, 2000, sets out the procedure for reporting and billing work status reports.
9. The services in dispute were reduced/denied by the respondent with the following reason codes:
Explanation of benefits
 - 29-The time limit for filing has expired.
 - Per rule 133.20; a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.

Issues

1. Does a timely filing issue exist?
2. Is the requestor entitled to reimbursement for the disputed services, CPT codes 99213-25, 29125, 73110-WP-RT?
3. Is the requestor entitled to reimbursement for HCPCS code L3908?
4. Is the requestor entitled to reimbursement for HCPCS codes E0190 and Q4022?
5. Is the requestor entitled to reimbursement for work status reports, CPT code 99080-73?

Findings

1. Texas Labor Code §408.027(a) states "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

28 Texas Administrative Code §102.4(h), states "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on:

(1) the date received, if sent by fax, personal delivery or electronic transmission or,

(2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five

days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday.

The requestor submitted reports that indicate the disputed bills were sent on December 27, 2011 for date of service September 23, 2011 and January 3, 2012 for date of service October 6, 2011. These dates are within the 95 day deadline set out in Texas Labor Code §408.027(a); therefore, the Division finds that the disputed bills were submitted timely to the insurance carrier. As a result, reimbursement is recommended for the disputed services per Division rules and guidelines.

2. Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2011 DWC conversion factor for this service is 54.54.

The Medicare Conversion Factor is 33.9764

Review of Box 32 on the CMS-1500 the services were rendered in zip code 78705, which is located in Austin, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for Austin, Texas.

Using the above formula, the Division finds the following:

Code	Calculation for Locality 0440218 Houston	Maximum Allowable
99213	(54.54/33.9764) 68.47 for 1 Unit	\$109.91
29125	(54.54/33.9764) x \$65.02 for 1 Unit	\$105.20
73110	(54.54/33.9764) x \$48.91 for 2 Units	\$117.02
		\$332.13

3. 28 Texas Administrative Code §134.203 (d)(1) states "The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:

(1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule."

On September 23, 2011, the requestor billed for HCPCS code L3908 that has a total allowable per DMEPOS of \$49.59. Per 28 Texas Administrative Code §134.203 (d)(1), the MAR is \$49.59 X 125% = \$61.98. The requestor is seeking \$55.00; this amount is recommended for reimbursement.

4. HCPCS code E0190 and Q4022 are codes that do not have a relative value unit or payment; therefore, reimbursement for these services are set out in 28 Texas Administrative Code §134.203 (f).

28 Texas Administrative Code §134.203 (f) states "For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)."

28 Texas Administrative Code §134.1, effective March 1, 2008, 33 TexReg 626, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(f) which states that "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."

Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

28 Texas Administrative Code §133.307(c)(2)(G) states the request for dispute resolution shall include: "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought of \$42.00 for HCPCS code Q4022 and \$50.00 for code E0190 would be a fair and reasonable rate of reimbursement. As a result payment cannot be recommended.

5. CPT code 99080-73 is defined as "Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form."

28 Texas Administrative Code §134.204 (I) states "The following shall apply to Work Status Reports. When billing for a Work Status Report that is not conducted as a part of the examinations outlined in subsections (i) and (j) of this section, refer to §129.5 of this title (relating to Work Status Reports)."

28 Texas Administrative Code §129.5(i)(1) states "Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be \$15. A doctor shall not bill in excess of \$15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section."

28 Texas Administrative Code §129.5 (d)(1) and (2) states "The doctor shall file the Work Status Report:

- (1) after the initial examination of the employee, regardless of the employee's work status;
- (2) when the employee experiences a change in work status or a substantial change in activity restrictions."

The requestor did not submit a copy of the September 23, 2011 report to support billing was in compliance with 28 Texas Administrative Code §129.5 (d)(1) and(2); therefore, reimbursement cannot be recommended.

The respondent submitted a copy of the work status report that dated October 6, 2011 that supports billing per 28 Texas Administrative Code §129.5 (d)(2); therefore, reimbursement of \$15.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$402.13.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$402.13 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	10/4/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.